FINAL MEETING SUMMARY

HANFORD ADVISORY BOARD
HEALTH, SAFETY AND ENVIRONMENTAL PROTECTION COMMITTEE
May 9, 2013
Richland, WA

Topics in this Meeting Summary

This is only a summary of issues and actions in this meeting. It may not fully represent the ideas discussed or opinions given. Examination of this document cannot equal or replace attendance and public participation.

Opening

Becky Holland, Health, Safety, and Environmental Protection Committee (HSEP) chair, welcomed the committee and introductions were made. She then reviewed the meeting agenda. The committee approved the summary of the April HSEP/Tank Waste Committee (TWC) joint meeting. No comments were received on the draft summary.

Beryllium Program Update*

* Please see Attachment 1 – Transcribed Flip Chart Notes for key points/follow up actions recorded during the committee discussion.

Agency presentation

Pete Garcia, U.S. Department of Energy – Richland Operations Office (DOE-RL), provided an update on the Hanford Site Chronic Beryllium Disease Prevention Program (CBDPP) (Attachment 2). During his presentation, Pete highlighted the following points:

- High-priority Phase 1 products were approved by DOE – Environmental Management (EM) in September 2011. These products have a high impact to worker health. Phase 2 and Phase 3 products were approved by DOE-EM in March 2013.
- Revision (Rev) 1 of the CBDPP was approved in 2012 and fully implemented across the entire Hanford Site in July 2012. As of April 1, 70% of the beryllium Corrective Action Plan (CAP) actions and 48% of beryllium CAP products have been completed.
- Currently, CBDPP Rev 2 is being prepared for submittal to DOE. Rev 2 contains the majority of the remaining major beryllium CAP products that will protect workers. Implementation of Rev 2 is expected in late summer 2013 after contractors complete an integrated implementation strategy and a pilot approach.
- Major beryllium CAP products included in Rev 2 are assessment/characterization/verification (A/C/V) of buildings and structures, beryllium postings, work controls, exposure monitoring, medical evaluations, and a beryllium counseling handbook for affected workers.

Committee discussion

Note: This section reflects individual questions, comments, and agency responses, as well as a synthesis where there were similar questions or comments. Questions, comments, and responses were provided by HAB members unless noted otherwise.

Q. Will DOE use the past negative history with beryllium response at the Hanford Site as a lessons learned opportunity? There were approximately 20 people who were known to be beryllium sensitized when the Beryllium Awareness Group (BAG) began their work; the number of affected workers is now in the hundreds at the Hanford Site alone. Many of these exposures could have been avoided.

> R. [DOE] *It would be valuable to use lessons learned on beryllium. Another valuable aspect of this program is that it can be applied at different sites, such as at Savannah River. The cost of the program was substantial but it can be reduced when being implemented at other sites.*

Q. How is the A/C/V sampling of buildings different than what has been done in the past? How will a facility suspected of containing beryllium be treated differently than a facility known to contain beryllium?

> *R. [DOE] The previous process for identifying buildings contaminated with beryllium was to examine known processes that occurred in that facility. The current A/C/V process considers the entire facility in more depth, from the concept of the building through its current use. Beryllium*

suspect areas (BSAs) are undergoing an A/C/V process. The first round will occur within the pilot program and then there will be a cross-cut of these different facilities to consider toxicity and gas structure. All buildings on the Hanford Site with the potential for beryllium contamination will need to undergo the A/C/V process.

Q. Do workers at the Hanford Site have an advocate? It is not sufficient to just provide workers with a handbook; they need someone that can offer emotional support.

R. [DOE] There is a site-wide advocate and a beryllium advocate with Mission Support Alliance (MSA). Both of these positions are filled by beryllium-affected workers, which make them particularly effective since the advocates have direct experience with the process.

C. One possible method of exposure for workers is from the porous nature of many of the buildings on the Hanford Site. Wind blowing through the buildings can disturb contaminants and cause exposures.

Agency presentation

Gail Splett, DOE-RL, presented information about former worker communications (Attachment 3). Her presentation detailed efforts being made to inform former Hanford Site workers about their risks of beryllium exposure and to offer medical screenings. In her presentation, Gail highlighted the following points:

- The Former Worker Medical Screening Program (FWP) is specifically designed to check for adverse health outcomes related to potentially hazardous exposures and is based on each individual's work and exposure history.
- There are two national projects covering Hanford Site former workers: the National Supplemental Screening Program and the Building Trades National Medical Screening Program. Exams are conducted in every state.
- The program is managed and funded independently from the Hanford Site. The primary role for Hanford is to provide roster data to help locate former workers that might have been at risk of exposure.
- 107,806 former Hanford employees have been contacted about FWP and beryllium risks since 1996. 9,225 screenings have been completed since 1998 and the number of screenings each year has increased since outreach began.

Karen Phillips, HPMC Occupational Medical Services (HPMC), presented information on beryllium statistics for Hanford employees (Attachment 4). She said there have been 131 Hanford Site workers identified as beryllium sensitized and 37 who have been diagnosed with chronic beryllium disease. Sensitized workers are predominantly male and the most common occupation was Radiation Control Technical or Nuclear Chemical Operator. Karen noted that three workers who were diagnosed as beryllium sensitized during their new hire exams were not likely exposed at the Hanford Site.

Committee discussion

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C. There were many subcontracted employees who worked at the Hanford Site for a short period of time, such as students who worked in the 300 Area over summer breaks. These workers will likely be hard to locate since their information might never have been provided to DOE or the contractor.

> *R. [DOE] One of the biggest challenges has been to locate workers, since DOE does not have complete records of everyone who has worked on the Hanford Site. DOE has taken every box of human resource records available and indexed them but does recognize there are some holes. DOE places ads in the papers and uses other means to inform potentially affected individuals.*

Q. Research seems to indicate that beryllium exposure is a precursor to lung cancer. Is there any information on how many former workers have lung cancer?

> *R. [HPMC] One portion of the medical screening includes complete chest x-rays. Former Hanford workers have higher asbestos-related lung issues than issues from beryllium exposure. The FWP includes any type of exposure that might be experienced at the Hanford Site. The question of whether there is an increased incidence of lung cancer in beryllium sensitized workers would be something to consider. That information is not currently included with the statistics presented today. One limitation in simply looking at the number of lung cancer cases is that it would be hard to separate out the cause of the cancer.*

Q. Were there any buildings identified as having beryllium contamination after beginning the more thorough investigation that were not originally suspected of containing beryllium?

> *R. [DOE] Yes, some buildings have been added to list of buildings with known beryllium contamination that were not thought to be at risk for contamination.*

Q. When will DOE assess the implementation of Rev 2?

> *R. [DOE] DOE will be assessing implementation throughout the roll out and during initial implementation. There will also be effectiveness reviews once Rev 2 becomes established.*

HSEP thanked DOE for providing the update and will continue tracking this topic. The committee will be interested in hearing about any lessons learned opportunities and the continuing efforts to reach out to former workers. HSEP would like a briefing from DOE after the effectiveness review for Rev 2 of the beryllium program is complete, potentially in January or February 2014.

January 2013 Plutonium Finishing Plant Contamination Event[*]

Issue Manager introduction

Keith Smith, Issue Manger (IM) for the Plutonium Finishing Plant (PFP) contamination event, said he initially became aware of the event after reading an article in the newspaper. His main concern is how and why the event occurred as well as what steps are being taken to ensure it does not happen again.

Agency presentation

Larry Romine, DOE-RL, provided a briefing on the contamination event at PFP (Attachment 5). He said the problem occurred with ten individuals who were working in two different rooms associated with a remote mechanical line. The incident took place in Room 235-A on the upper level of a glove box during the cutting of a horsetail. This procedure required workers to execute a wet towel technique. Four workers were sealing a small package when one of the workers pulled back a little on the wet towel and exposed the horsetail. These four workers were separated from other workers in the area by a rope when the alarm in Room 235-A sounded. They immediately exited to Room 232. Under emergency planning procedures, the workers already in Room 232 should have exited to another room before the four workers in the alarmed area entered. Instead,, the workers in Room 232 stayed to help their colleagues; an alarm subsequently sounded in Room 232.The workers in Room 232 did not have the same protective equipment as the four workers from Room 235-A,; they were the ones with the potential uptake. Four individuals had positive nasal smear test results.

Larry said lessons learned from this event include the need for a better understanding of how air flows through facilities and training workers on their responsibilities during these types of events. The exposure to workers during this event was relatively small in comparison to what it could have been, although Larry said all exposures should be avoided. Larry referenced a larger presentation with 30-40 slides detailing the root and contributing causes to the incident.

Committee discussion

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C. There is a major difference between exposure from gamma and alpha; gamma exposure is much more serious.

C. The wet towel wrapping procedure sounds reasonable but it also sounds very flexible. Is there a standard procedure or training? Has DOE considered ways to improve the towel wrapping procedure?

[*] Please see Attachment 1 – Transcribed Flip Chart Notes for key points/follow up actions recorded during the committee discussion.

R. [DOE] The procedure is done all over the world and crews at the Hanford Site perform it at least 150 times a month without any incidents. When possible, crews use other methods but there are not a lot of options for dealing with older glove boxes. Respirators are required. The method of work is not as concerning as the response when the workers stepped off the pad. Protocol is for the workers without the same personal protective equipment to leave. In this instance workers stayed behind to help their colleagues. DOE's drills usually simulate much more dramatic occurrences than the minor incidents that would likely be more common as a result of day-to-day operations.

C. Usually the towel method works well; it sounds like something just got away in this case. Was the decision not to use a vacuum a result of the tight work area?

R. [DOE] The work area is very constrained and workers had convinced themselves the additional protection was unnecessary since the procedure has been performed so many times without incident. That option is no longer available and there will be an independent investigation into the incident.

Q. Did workers know from the pre-job what they should do if an alarm sounded?

R. [DOE] DOE was not present at the pre-job briefing and cannot speak to what was discussed. The point is well-taken and DOE recognizes the importance of specifying roles in response to incidents. Communication is very important.

Q. Is there a record of what was discussed during the pre-job briefing?

R. There is a checklist for the pre-job. The pre-job should have covered what workers are expected do in case of emergency. The procedure when an alarm goes off is to move into a different airspace. The concern in this instance is that some people remained in the same airspace without protection. Also, a worker stated there was 1600 without specifying the measure so workers assumed 1600 disintegrations per minute (dpm) when it was actually 1600 count.

The committee did not identify any follow up items for this topic and thanked DOE for providing the information.

Incidents with Portable Tank Exhausters[*]

Agency presentation

Chris Kemp, DOE – Office of River Protection (ORP), provided a presentation on the C-Farm Portable Exhauster Discussion (Attachment 6). He referenced a map of the C Farm Ventilation System

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(Attachment 7) to illustrate where the incident occurred. During his presentation, Chris described how the C Farm exhausters work using a schematic illustration, and noted the following points:

- There are three Skid Mounted Exhausters used in C-Farm Retrievals: POR-03 has a 500 ft^3/minute capacity, POR-08 has a 1,000 ft^3/minute capacity, and POR-107 has a 3,000 ft^3/minute capacity. POR-107 and POR-03 use a common header connected to tanks during retrieval while POR-08 has its own ductwork header.

- There were two events at POR-107. The first event was on August 19, 2011 when the solid state relay burned up and the circuit energized sending full power to the heater core. The second event was on February 12, 2013. During operator training there was smoke/steam observed from the propylene glycol mixture boiling off. Emergency crews responded to both incidents.

- DOE has not been able to replicate the 2013 event, which makes it difficult to determination how to correct it.

- One issue DOE has been addressing is that valves were installed downward, which the manufacturer has said can increase the potential for leakage. Stems should be installed at 90 degree angles. DOE has been reinstalling valves with ARRA money and most of the gasket materials have been replaced.

Regulator's perspectives

John Martell, Washington State Department of Health (W-DOH), said W-DOH manages radioactive air emissions. All exhausters have met the requirements for air exhaust. DOE notified W-DOH about both of the incidents. W-DOH completed an inspection of the exhauster to ensure the high-efficiency particle air (HEPA) filter was still adequate and that there was no heat damage. W-DOH did not see an impact to the HEPA filter and there was no increase in radiation emissions in the stacks. The cause of the POR-107 incident has not been fully explained.

> *R. [DOE] The cause of the incident was essentially that the heater stayed on but DOE has not been able to replicate how that happened.*

Committee discussion

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C. During the 2011 incident, insulation was burned around the outside of the heater. The Hanford Fire Department had to remove the material and spray it down with several gallons of water. The 2013 incident had similar results.

C. Another issue is that the data logger did not record information from the August 2011 incident. The logger has since been fixed so it would be useful to see if anything was recorded during the February 2013 incident. This question was noted as a follow-up for future HSEP conversations.

Q. Is the exhauster required when transferring waste also required when workers are doing intrusive work unless they are wearing respirator?

> *R. [DOE] Workers are required to use the exhauster whenever conducting any waste-disturbing activity. Exhausters are also used during additional procedures that might not be termed "waste disruptive" such as pit work.*

C. Managing the ventilation system is a very difficult technical issue. There is a concern about condensation in the duct work. Will DOE need to replace the duct work to meet radiation control standards because of increased doses?

> *R. [DOE] DOE is aware that there is a dose increase on duct work in places.*

C. The last reported valve leak was in February. Was that repaired?

> *R. [DOE] The leaking valve from February was repaired. There has also been another leaking valve reported last week. DOE offered to show HSEP members the repair.*

HSEP would like to verify repairs on the valves. Becky will continue following this issue as IM to see if there are other areas of concern for HSEP.

Follow-Up on Safety Culture Progress (Joint with TWC)[*]

Issue Manager introduction

Liz Mattson, one of the IMs for the safety culture topic, said this conversation is a follow up to the Hanford Advisory Board's (Board or HAB's) safety culture advice. HSEP asked DOE to continue providing updates to the committee since safety culture is an ongoing process.

Dirk Dunning, the other IM for the safety culture topic, mentioned the issues with tank AY 102 as an example of problems with Hanford Site safety culture. Engineers identified that the tank was leaking and management overrode their concerns. It was over a year before the leak became public knowledge and for the regulators to become involved. The committee would like to understand what happened in that instance, why it happened, and how to revise the safety culture to ensure it does not happen again.

Agency presentation

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Steve Pfaff, DOE-ORP, provided a briefing on DOE's synthesis of DOE-ORP's "self assessment" responses provided to the Defense Nuclear Facilities Safety Board (DNFSB) in March 2013 (this synthesis did not include the results from contractor self-assessments). He said he would not be speaking in specifics today and would provide an overview of the assessments. During his presentation, Steve noted the following points:

- Kevin Smith, DOE-ORP, is assembling a group of DOE-ORP managers and a team of off-site individuals to investigate DOE-ORP and the tank farm contractor's safety systems, especially how issues are monitored and reported. Washington River Protection Solutions (WRPS) was directed to complete the same type of evaluation.

- DOE agrees that tank AY 102 is a safety culture issue. News reports have stated that the issue was raised a long time ago by a worker and the issue was ignored. The leak is only now becoming public knowledge.

- The DNSFB issued a recommendation in 2011 regarding safety culture at the Waste Treatment and Immobilization Plant (WTP). A second report in 2012 evaluated WTP and DOE-ORP using behavioral scientists to better capture what workers are thinking and feeling.

- DOE is required to issue an implementation plan. In that plan, DOE states they will define improvement actions from the DOE – Office of Health, Safety and Security (HSS) report. DOE-ORP produced an improvement plan that identifies nine near-term actions to be completed within a year.

- DOE – Headquarters (HQ) provided criteria for DOE-ORP to complete a self-assessment. The self-assessment had four objectives for a safety conscious work environment that included leadership, employee engagement and organizational learning.

- The assessment was modeled like DOE-HSS efforts. DOE conducted 31 individual interviews and held seven focus groups. Focus groups can be less threatening and bring out more information than individual interviews.

- Strengths identified from the self assessment include a willingness of employees to share their feedback about safety culture, strong working relationships between employees and their direct supervisors, establishment of the Issue Management System and optimism about the new DOE-ORP manager.

- DOE also identified nine near-term improvement actions to continue working on over the coming year.

Committee discussion

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C. There is a concern that DOE is not open to criticism, which renders any safety culture ineffective. It is unclear that the self-assessment would capture the issue. DOE believes they have the safety culture issue under control and have not recognized the value in principles of behavior. This behavior is reflected by DOE to the contractors.

> *R. [DOE] The self assessment did not have any indicators that would validate or invalidate this concern. Interviewees were asked questions such as if they are willing to raise issues with DOE-ORP management. At least within DOE-ORP, workers appear willing to raise concerns with their direct supervisors.*

C. Communication at DOE does not appear to have improved over the previous year.

> *R. [DOE] There have been improvements but improvements are not to the point where everyone is fully satisfied. All-employee meetings are much better, with more timely information on a much better basis since Kevin Smith came into the program. There is also better attendance at the meetings as workers are more aware of the benefits of being there. DOE-ORP has developed a list of cleanup priorities between DOE management, the Washington State Department of Ecology (Ecology) and the U.S. Environmental Protection Agency (EPA). This list is under discussion as funding at the Hanford Site is limited and decisions need to be made about what cleanup work gets funded and what work gets delayed. DOE management is making an effort to get to know employees by holding pizza lunches with employees and instituting mentorship groups.*

C. The committee appreciates these updates from DOE and knowing there is substance behind the safety culture efforts. It has been useful to see how concerns about safety culture were investigated and addressed with an acknowledgment that concerns about safety culture are not isolated cases; there has been a systematic problem at the Hanford Site.

Q. Are Safety Culture Improvement Team meeting discussions formal or fairly informal/open?

> *R. [DOE] Conversations within the team are very open. Everyone on the team would like to see actual improvements within the safety culture program, so conversations have been productive. The final proof will be in whether the management team has committed to safety culture and how much attention will be paid to the program. There has been progress but not enough to fully see results of the program.*

Q. Is Bechtel part of the self-assessment process?

R. [DOE] Bechtel will complete their own self assessment. WRPS also completed an individual self-assessment. DOE has oversight of Bechtel and are working with them to develop their assessment plan.

C. All personnel meetings are a good way to accelerate transformation by having management demonstrate principles of behavior that trickle down through the workforce. Management can gain respect and hear feedback if they are able to respond to safety concerns in front of a thousand people during an all-employee meeting.

C. It is also important that workers are not criticized if they bring up a concern that turns out not to be an issue.

R. [DOE] There are not very many examples of that occurring from DOE-ORP. There was a case where a potential safety issue was brought forward by an individual who had a concern about the methods for cutting tanks that was thoroughly investigated over the course of several months. Ultimately it was decided that the initial approach was valid so no changes were made. The individual who raised the concern was able to work through the issue professionally and did not appear to suffer any ill effects or retribution.

C. It is important that people take ownership and determine their responsibilities.

R. [DOE] DOE considered the role of individual responsibility when drafting the improvement plan. It is important to work as a team to resolve issues and actively ensure all concerns are raised. These are points DOE would like to emphasize, such as a focus on positive reinforcement and encouraging appropriate behaviors; the team aspect could be emphasized to a greater extent.

Becky will follow up on this topic as IM. The committee would like to continue hearing updates from DOE about safety culture progress and would like a briefing when the HSS Report is available, likely in the December or January timeframe. DOE will be completing the Effectiveness Review at the end of May and the Safety Culture Improvement Plan is scheduled to be completed in June. DOE offered to brief the committee on both of these topics. The committee will tentatively plan to hear an update from DOE during the August or September HSEP meeting.

Buildup of Flammable Gas in the Double-Shell Tanks (Joint with TWC)[*]

Issue Manager introduction

Dirk, IM for the flammable gas topic for TWC, said there was a similar issue in the 1990's when many of the tanks were generating hydrogen gas. The problem was serious enough that tanks were placed on a

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watch list and it took a long time to remove tanks from this list. Dirk said the current problem is related to this past issue; sludge in the double-shell tanks (DSTs) is accumulating waste gas that can result in a buoyant displacement gas release event (BDGRE). There are two documents that are particularly useful in describing the issue: Pacific Northwest National Laboratory (PNNL) Document 15238 and Radiation Protection Program (RPP) Document 23836. Gas released in the tanks could lead to flammability in the tanks and create an explosion. The current question regards the seriousness of the situation. PNNL is considering modeling data to determine the risks but there are limitations with the models. Dirk said the purpose of the HSEP discussion is to ensure that the committee understands some of the big issues and, if HSEP/TWC would like, an IM group can continue speaking with the agencies and start determining next steps for potential future advice.

Agency perspectives

Kim Ballinger, DOE-ORP, said DOE is currently working on a response to the DNFSB regarding the DST issue. Someone from DOE may be able to speak with HSEP after the report is finalized, potentially in August.

John Martell, W-DOH, said W-DOH has evaluated the concern over BDGRE. W-DOH is primarily concerned with ensuring that the ventilation system continues to operate and that it is able to handle any event without any unmonitored, unfiltered gas releases. W-DOH is responsible for radiological releases and Ecology deals with non-radiological releases.

Committee discussion

Note: This section reflects individual questions, comments, and agency responses, as well as a synthesis where there were similar questions or comments. Questions, comments, and responses were provided by HAB members unless noted otherwise.

Q. There are several framing questions the committees can consider for this topic. First, is the current safety basis adequate to address these risks? Second, how will new findings be incorporated into the safety basis? Third, what is the safety basis for the DSTs that would take this problem fully into account?

C. HSEP is also focused on the safety of transferring waste from the DSTs to the WTP. The waste transfer process and retrieval process is obviously disruptive. The safety basis should take these processes into account.

C. It is important to plan for the worst case scenario and have emergency plans in place. The Hanford Site held drills in the 1990's that simulated tank explosions and major releases to the environment.

C. A flammable event might be possible but an explosion appears to be unlikely based on information in the PNNL Report. The tanks do not appear to reach high enough temperatures to explode. However, emergency planning always involves planning for the event that did not seem possible; DOE should have plans in place on what to do in the event of an explosion.

Q. One question the committees could ask DOE is what types of gases are being released and how those releases are monitored. There is also interest in understanding why the Standard Hydrogen Monitoring System (SHMS) cabinets were removed. These cabinets were installed in the tank farms and were removed using American Recovery and Reinvestment Act (ARRA) funding as part of upgrades to the exhausters. The exhausters currently in the tank farms are not reliable and frequently shut down. HSEP would like to know how hydrogen is currently being monitored in the tank farms.

C. Pressurization alarms often do not work. When these alarms are not functioning workers are told to rely on someone with a megaphone to announce if there is an emergency. This is s serious problem in the field. People have become complacent about the alarms not working.

R. [DOE] Has that issue been reported? DOE will share this concern with management.

The committee felt they developed a solid set of framing questions and would like DOE to address these questions during a potential August committee meeting. DOE will check on the availability of appropriate staff and timeliness of the topic.

Committee Business[*]

DOE Response to HAB Advice #260 (Integrated Safety Management)

The committee reviewed DOE's response (Attachment 7) to HAB Advice #260 (Integrated Safety Management) (Attachment 8). This response was discussed during the March committee call (lightly attended) and there were some HSEP members who felt there should be a conversation with more committee members to determine if there should be follow-up steps from HSEP.

Some committee members felt DOE was initially trying to dissuade the Board from offering the advice and that DOE's response to the advice basically stated that DOE agrees with the Board's advice and are already implementing the recommended actions. The response does not include a statement of support for the use of contractor self assessments or the 360 review. It does not appear DOE is making any commitments to change based on the advice, though staff members appeared to agree with the Board's points during advice development discussions. DOE stated that several of the Board's ideas were good and that they would follow-up on these points, but the response to the advice presents very different information.

HSEP noted that there may be another opportunity for advice when the self assessment is available. The Board could also draft a letter to DOE stating that they believe the response is inadequate or invite DOE to come to an HSEP meeting and review DOE's response to the advice point by point. HSEP decided a

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conversation with DOE staff would be more useful than receiving another written response. DOE requested that HSEP be specific about the information they would like from DOE.

Update the 3-month work plan

HSEP updated their 3-month work plan. There were no topics identified that would be timely for June and there are no committee meetings in July. HSEP identified several topics for discussion during a potential August meeting, including the effects of radiation on concrete, continuation of the safety culture discussion and further discussion about BDGREs in the DSTs. There is also interest in discussing the regulatory oversight for lands that are being transitioned into Long-Term Stewardship (LTS) from an HSEP perspective; this topic would be joint with the River and Plateau Committee since they have been following the LTS topic.

HSEP decided not to hold a May committee call but will have calls in June and August. The June call will address the response to HAB Advice #265 (Independent Evaluation of Procedures and Industrial Hygiene Equipment Used to Monitor Tank Vapors and Flammable Gas), and the HSEP topics in the proposed 2014 HAB work plan. The July call will focus on agenda development for a potential August meeting.

Attachments

Attachment 1: Transcribed Flip Chart Notes
Attachment 2: Update on the Hanford Site Chronic Beryllium Disease Prevention Program
Attachment 3: Former Worker Communications
Attachment 4: Beryllium Statistics for Hanford Employees
Attachment 5: Plutonium Finishing Plant Contamination Event
Attachment 5: C-Farm Portable Exhauster Discussion
Attachment 6: C-Farm Ventilation Systems
Attachment 7: DOE Response to HAB Advice #260 (Integrated Safety Management)
Attachment 8: HAB Advice #260 (Integrated Safety Management)
Attachment 9: 3-Month Work Plan

Attendees

HAB Members & Alternates

David Bernhard	Laura Hanses	Liz Mattson
Richard Bloom	Steve Hudson	Melanie Meyers (phone)
Tom Carpenter (phone)	Mike Korenko	Keith Smith (phone)
Sam Dechter	Rebecca Holland	Margery Swint

Others

CJ Kemp, DOE-ORP	Erika Holmes, Ecology	Mark Fisher, CHPRC
Steve Pfaff, DOE-ORP		JM Swarr, CHPRC
Rich Urie, DOE-ORP		Alex Nazarali, CTUIR
Kim Ballinger, DOE-RL		Mike Stoner, HAMTC
Pete Garcia, DOE-RL		Karen Phillips, HPMC
Larry Romine, DOE-RL		Sharon Braswell, MSA
Gail Splett, DOE-RL		Michael Turner, MSA
		Bill Pollard, S&H
		John Martell, W-DOH